STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/30/12 Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Markle Health and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111)	K0000	The creation & submission of this Plan of Correction does not constitute an admission by this provider of any conlusion set forth in the statement of deficiencies, or of any violation of regulation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the resident rooms on the 300 hall, in the corridors, and areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms on the 100 and 200 halls. The facility has a capacity of 100 and had a census of 80 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where residents have customary access were sprinklered. The facility had two detached sheds providing facility services including activity and therapy supplies that were not sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/01/12. The facility was found not in compliance with the aforementioned regulatory			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any staff and resident in the conference room. Findings include: Based on an observation with the Environmental Supervisor on 07/30/12 at 1:30 p.m., there were three penetrations in the conference room storage closet ceiling that had been seal with fire caulk but the caulk had shrunk	K0025	K025 It is the practice of this facility to ensure that smoke barriers are constructed to provide at least a one half hours fire resistance rating in accordance with 8.3. and that smoke barriers may terminate at an atrium wall. It is also the practice of this facility to ensure that windows are protected by fire-rated glazing or by wired glass panels and steel frames & that a minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations orf smoke barriers in fully ducted heating, ventilating, and air conditioning systems. I. Corrective Action Taken: The 3 penetrations in the conference room storage closet ceiling have been resealed.II. Identification of Other Residents Having the Potential of the Same Deficient Practice: Maintenance performed an inspection of all closets to identifiy any other areas that	08/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	leaving unseal gaps measuring from one fourth inch to one inch. This was acknowledged by the Environmental Supervisor at the time of observation. 3.1-19(b)		needed to be resealed. No other closets were affected. III. Measures Put in Place: Maintenance Supervisor will monitor on a quarterly basis by performing a visual inspection of each closet area with ceiling penetrations.IV. Monitoring of Corrective Action:Maintenance Supervisor will complete an audit log when preforming each quarterly inspection. Completed audit logs will be reviewed by the C.Q.I. committee each quarter for compliance and/or recommendations.Completion Date: 8-29-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 3 of 5 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" This deficient practice could affect any residents evacuated through the 100 hall, 200 hall and the main entrance. Findings include: Based on observations with the Environmental Supervisor on 07/30/12 from 1:40 p.m. to 3:00 p.m., the exit doors on the 100	K0038	K038It is the practice of this facility to ensure exit access is arranged so that exits are readily accessible at all times in accordance with sectioin 7.1.I. Corrective Action Taken: Required signage is now in place on the 100 hall, 200 hall, & main entrance doors.II. Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:Maintenance Supervisor has performed a visual audit of all eixt doors to ensure placement of proper signage.III. Measures Put In Place:Maintenance Supervisor will perform a visual audit each quarter to ensure signage is still in place & complete an audit log at the time of the visual audit.IV. Monitoring of Corrective Action Taken:Maintenance will present findings quarterly during the CQI meetings for review & recommendations by the CQI team.Completion Date: 8-29-12	08/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hall, 200 hall and the main entrance were equipped with electromagnetic locks that released after pushing the crash bar for fifteen seconds, but lacked the proper signage. This was acknowledged by the Environmental Supervisor at the time of observations. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect any number of residents, staff and visitors. Findings include: Based on record review of Integrated Electronics report titled "Smoke Detector Sensitivity Test Report" with the Environmental	K0052	K052It is the practice of this facility to ensure the fire alarm system required for life safety is installed, tested, & maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and teesting program complying with applicable requirements of NFPA 70 and 72.I. Corrective Action TakenA revised report has been provided to facility by the contracted company who performed the smoke detector sensitivity test.II. Identification of Other Residents Having the Potential to be Affected by the Deficient Practice:Contracted company has completed a detailed count of smoke detectors in the facility & completed another sensitivity test. III. Measures Put In Place:Upon receipt of new report, maintenance supervisor will review the completed report provided by the contracted company & monitor for any discrepencies. If discrepencies are found, maintenance supervisor will immediately notify the contracted company who performed the sensitivity test for	08/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Supervisor on 07/30/12 at 12:22 p.m., the form indicated fifty smoke detectors in the facility received a sensitivity test. Review of the Integrated Electronics annual function test titled "Initiating and Supervisory Device" the form indicated fifty one smoke detectors received an annual function test. The Environmental Supervisor could not explain the discrepancy in the number of smoke detectors listed in the inspection reports. 3.1-19(b)		prompt follow up/corrections.IV. Monitoring of Corrective Action Taken:Maintenance will provide facility ED with a copy of the final sensitivity test reports & ED will monitor/review the report for any descrepencies in documented numbers of smoke detectors. Completion Date: 8/29/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 4 corridors. This deficient practice could affect any resident evacuated through the service hall in the event of an emergency. Findings include: Based on observation with the Environmental Supervisor on 07/30/12 at 2:30 p.m., four large full soiled linen containers were unattended and stored in the service hall adjacent to the laundry room. Based on an interview with the Environmental Supervisor at the time of observation, he stated each	K0075	K0075It is the practice of this facility to ensure soiled linen or trash collection receptacles do not exceed 32 gal in capacity. It is also the practice of this facility to ensure the average density of container capacity in a room or space does not exceed .5gal/sq ft (20.4 L/sq m) & the capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. It is also the practice of this facility to ensure mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended.I. Corrective Action Taken:The four large linen containers were removed from the service hallway.II. Identification of Other Residents Having the Potential to be Affected by this Same Deficient Practice:Staff has been inserviced about the requirement to bag all soiled laundry & trash before putting into soiled barrels. Inservice was completed by	08/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155673	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	container is stored in the service hall until it is taken into the laundry room. 3.1-19(b)		Maintenance Supervisor by 8-29-12.III. Measures Put in Place.Soiled linen containers are no longer stored in the service hallway. They are now kept in the shower rooms until they can be taken directly into the laundry room by C.N.A.'s & laundry staff. Maintenance Supervisor/designee will monitor 1 x daily during walking rounds. Weekend managers/designee will monitor 1 x during each weekend day worked. Compliance will be documented on an audit log.IV. Monitoring of Corrective Action Taken:Maintenance Supervisor will present the completed audit tools to the monthly CQI committee for review/recommendations x 6 months & quarterly thereafter. Completion Date: 8/29/12	